9STATE OF MARYLAND
DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

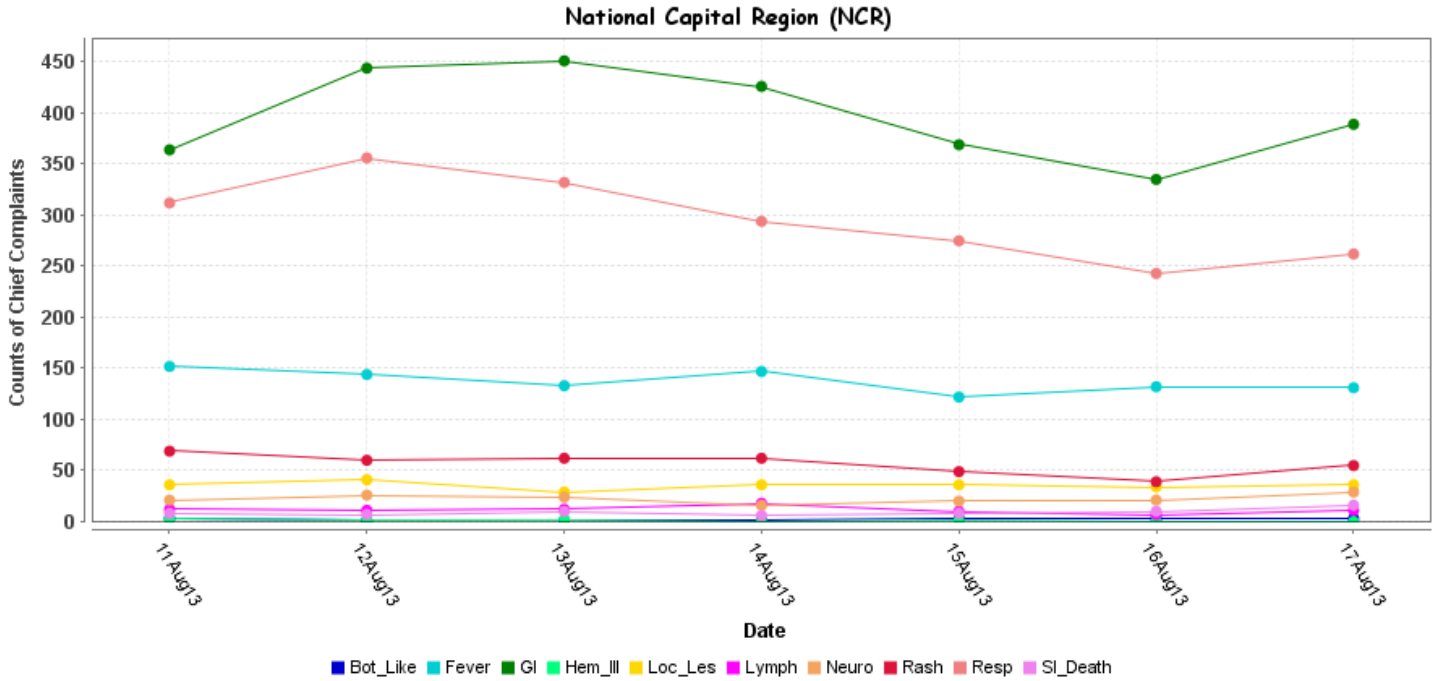
August 23, 2013

Public Health & Emergency Preparedness Bulletin: # 2013:33
Reporting for the week ending 08/17/13 (MMWR Week #33)

CURRENT HOMELAND SECURITY THREAT LEVELS

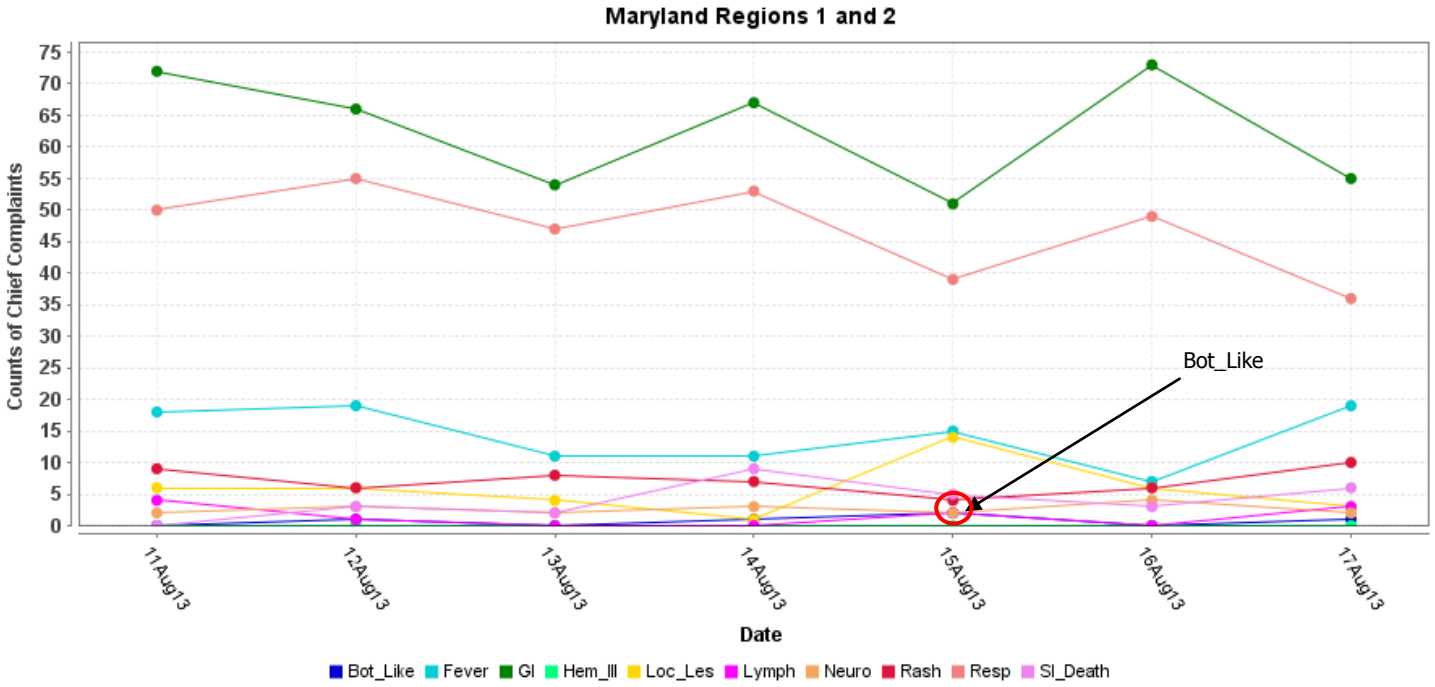
National: **No Active Alerts**
Maryland: **Level Four (MEMA status)**

SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

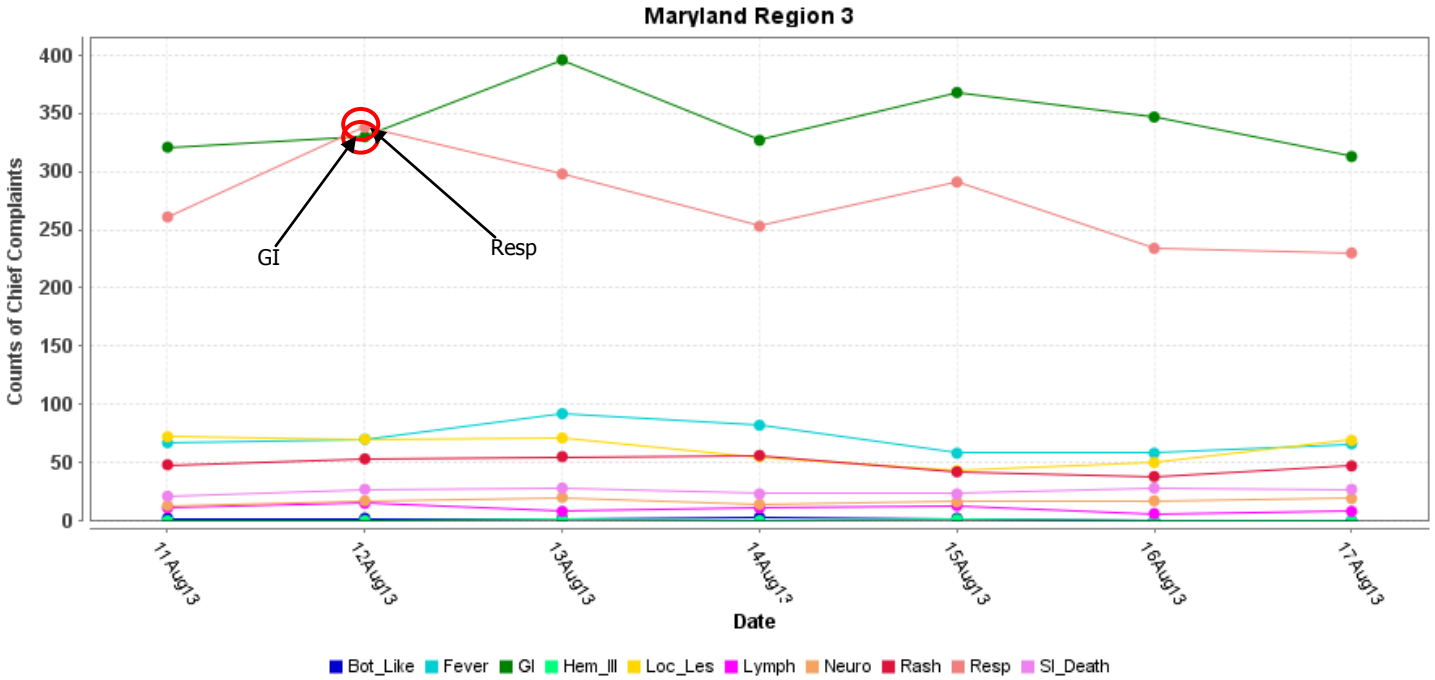


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

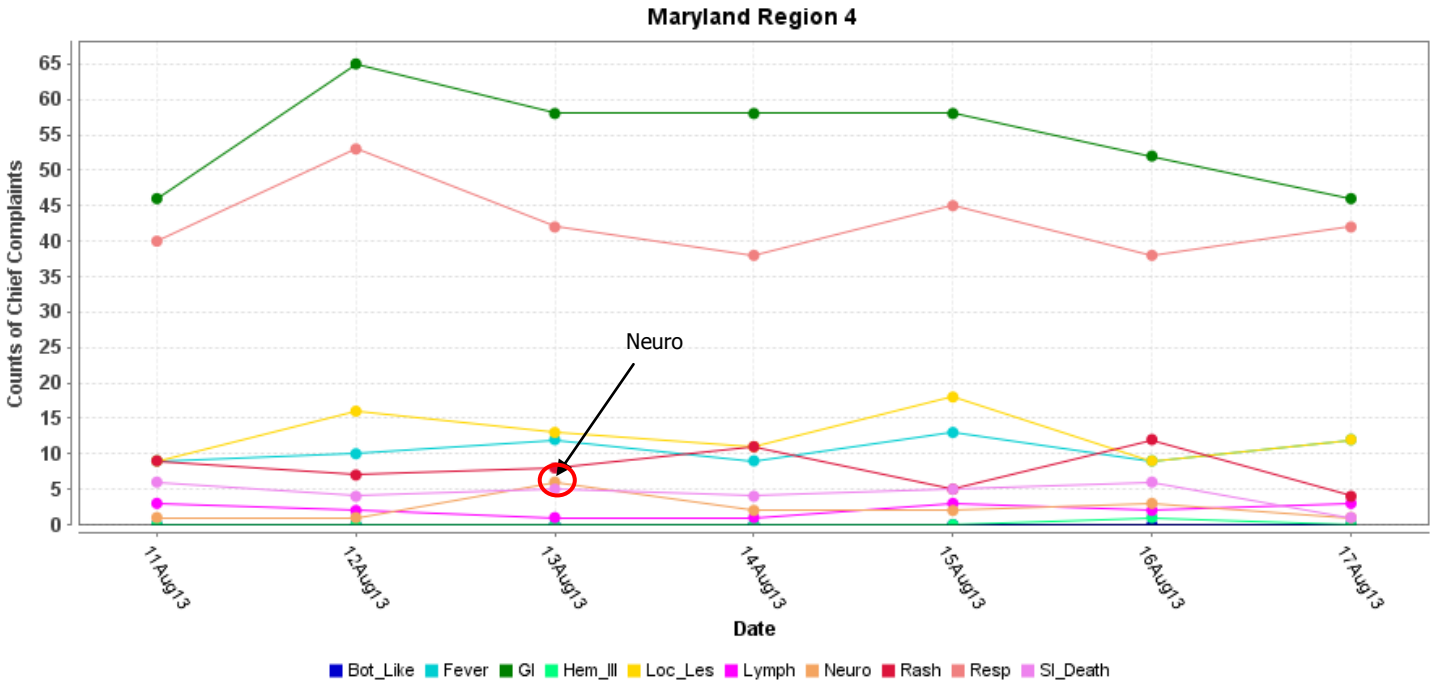
MARYLAND ESSENCE:



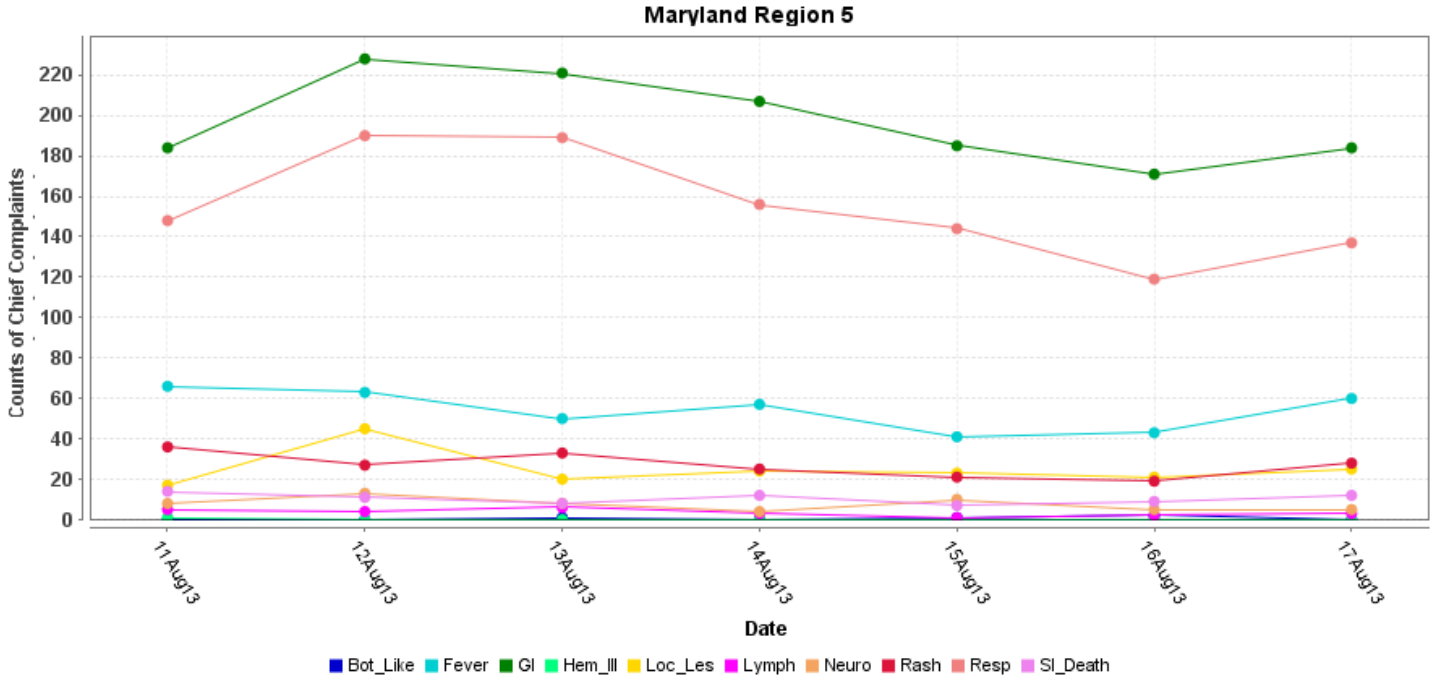
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



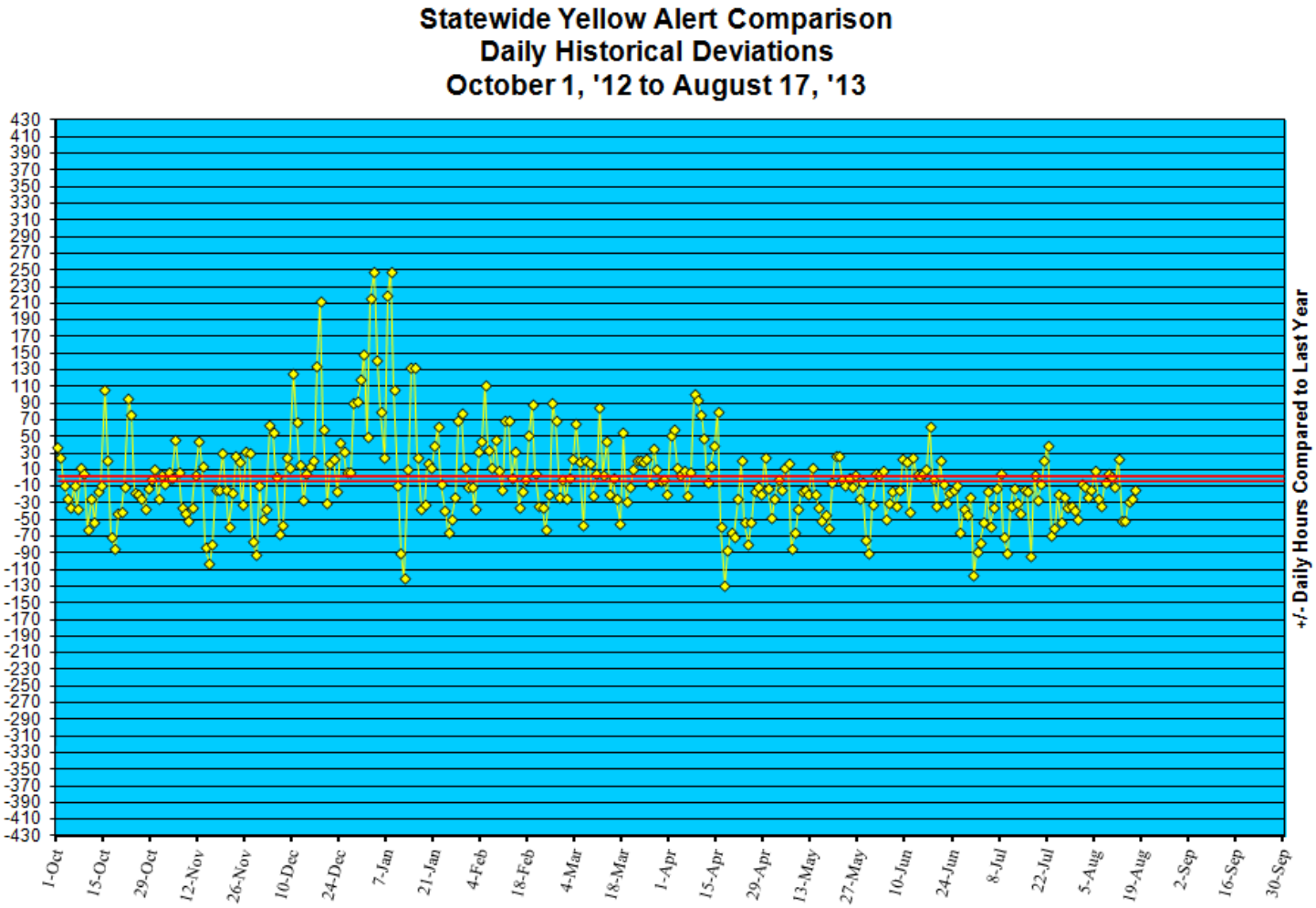
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/11.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in July 2013 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (August 11 - August 17, 2013):	11	0
Prior week (August 4 - August 10, 2013):	8	0
Week#33, 2012 (August 13 – August 19, 2012):	21	0

3 outbreaks were reported to DHMH during MMWR Week 33 (August 11 – August 17, 2013)

3 Respiratory Illness Outbreaks
1 outbreak of LEGIONELLOSIS in an Institution
1 outbreak of PNEUMONIA in a Nursing Home
1 outbreak of AFRD in a NURSING Home

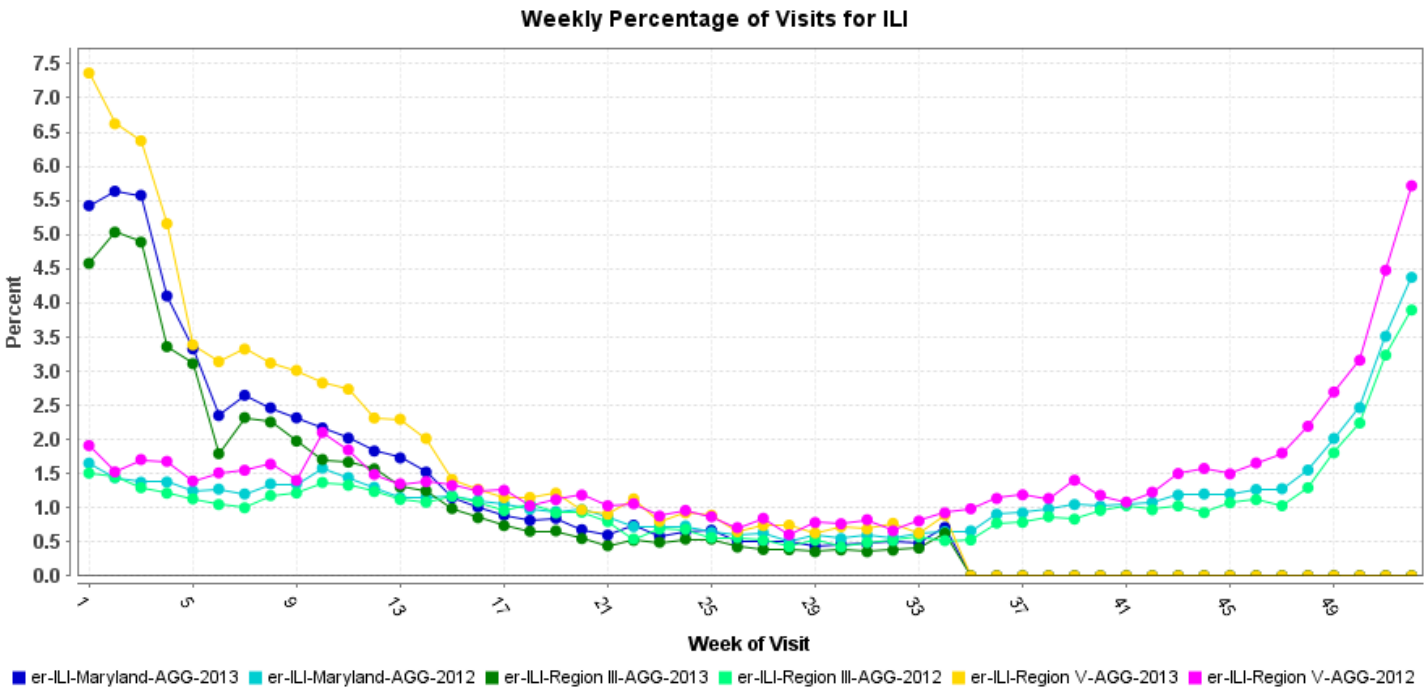
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May.

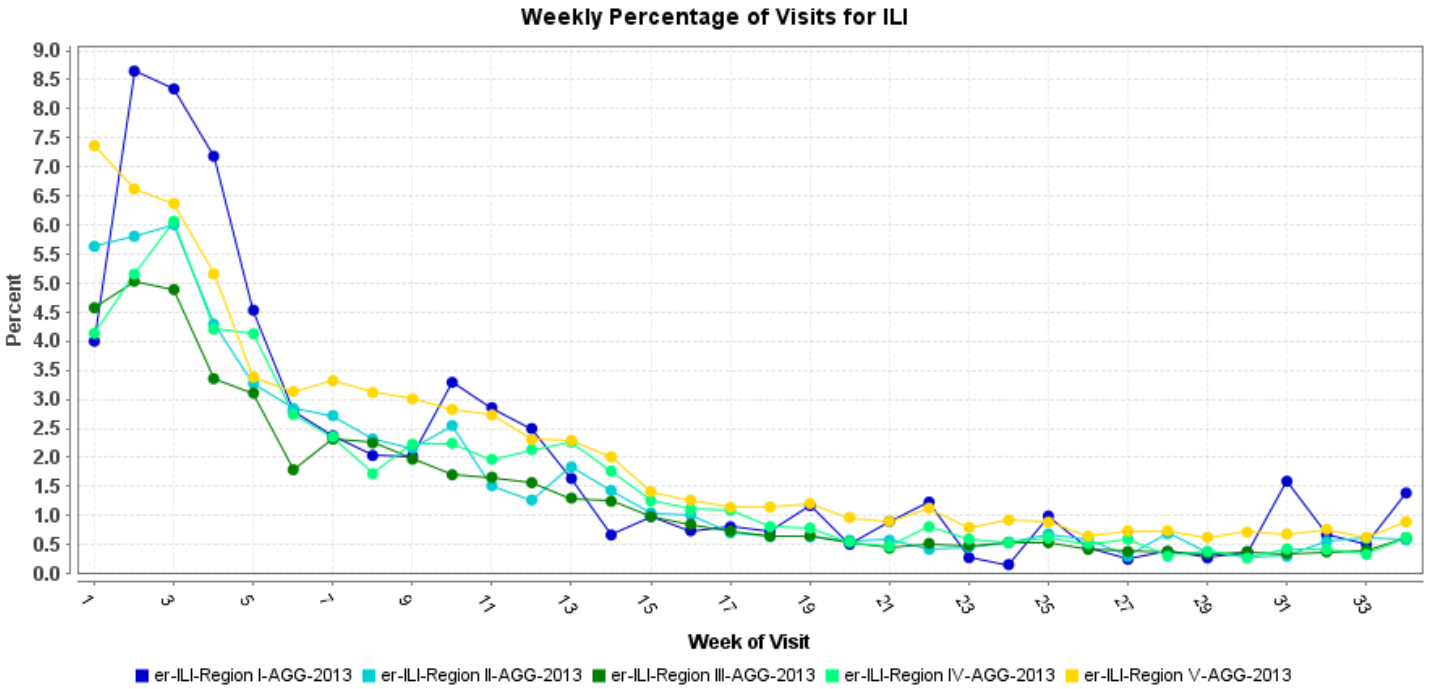
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



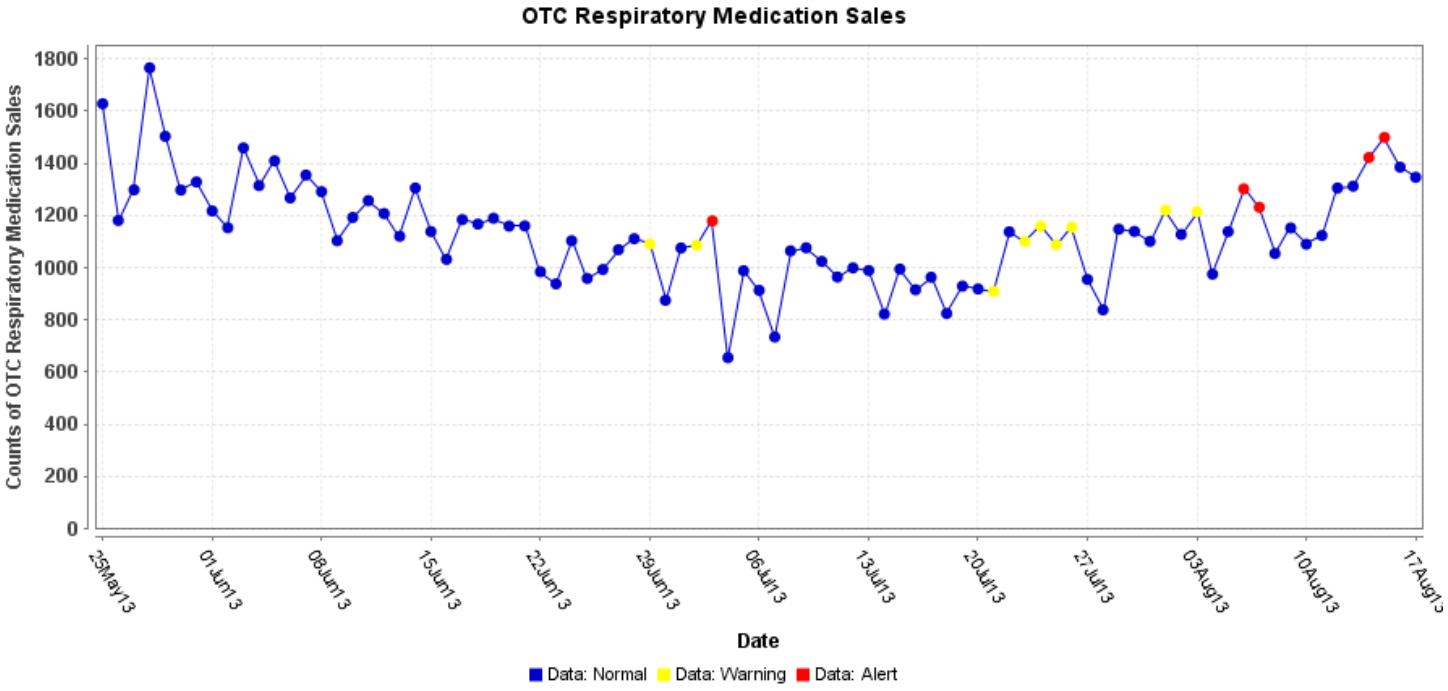
* Includes 2012 and 2013 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2013 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of July 5, 2013, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 633, of which 377 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 60%.

AVIAN INFLUENZA, HUMAN, H5N1: Two more new human cases of avian influenza have been confirmed for the H5N1 virus in Cambodia, bringing the number of cases to 16 so far this year [2013], a joint statement by the World Health Organization and the Cambodian Health Ministry said on Tuesday [13 Aug 2013]. The statement said that one case is a 9 year old boy from north western Battambang Province, who was admitted to the Jayavarman VII Hospital in Siem Reap with fever, cough, vomiting, abdominal pain, and dyspnea [difficulty breathing] on 4 Aug 2013, and was confirmed positive for human H5N1 avian influenza on Friday last week [9 Aug 2013]. "The boy is currently in a stable condition," the statement said. The other case is a 5 year old girl from Southern Kandal Province who was admitted to Kantha Bopha Hospital in Phnom Penh on Friday last week [9 Aug 2013] with fever, cough, sore throat, abdominal pain, diarrhea, and dyspnea, and she was confirmed positive for human H5N1 avian influenza a day later. "The girl was treated with Tamiflu and is currently in a critical condition," it said. The 2 patients touched dead or sick poultry before they became sick, the statement said. Avian influenza H5N1 remains a serious threat to the health of all Cambodians, Health Minister Mam Bunheng said. "Children also seem to be most vulnerable and are at high risk because they like to play where poultry are found," he said in the statement. "I urge parents and guardians to keep children away from sick or dead poultry and make sure children wash their hands with soap and water after any contact with poultry." Avian H5N1 influenza is a virus that normally spreads between sick poultry, but it can sometimes spread from poultry to humans, the statement said, adding that it is a very serious disease that requires hospitalisation. Cambodia has seen the worst outbreak of the virus this year [2013] since the disease was 1st identified in 2004. To date, the country has recorded 37 human cases of the virus, killing 28 people. This year, only 5 out of the 16 cases survived. Globally since 2003, there have been 636 laboratory confirmed human cases of H5N1 virus with 377 related deaths, the statement said.

AVIAN INFLUENZA, HUMAN, H7N9: A man infected with H7N9 avian influenza died of multiple organ failure on Mon 12 Aug 2013, local authorities said. The 61 year old patient was transferred from the city of Langfan in north China's Hebei Province to Beijing Chaoyang Hospital for treatment on 18 Jul 2013. He tested positive for the H7N9 virus on 20 Jul 2013. A single human infection of H7N9 was confirmed in south China's Guangdong Province on Friday [9 Aug 2013], bringing the total number of infections on the Chinese mainland to 134 this year [2013]. 44 of the infections have resulted in death. The health authorities halted their emergency response to the H7N9 outbreak in late May 2013. However, a spokesman for the National Health and Family Planning Commission said the authorities have been monitoring the situation and are preparing for possible outbreaks in the coming fall and winter [2013-14]. Earlier this month [August 2013], researchers in east China's Jiangsu Province said the H7N9 virus might be capable of human-to-human transmission. However, they added that such transmissions are limited and non-sustainable.

NATIONAL DISEASE REPORTS*

VIBRIO PARAHAEMOLYTICUS (CONNECTICUT): 17 August 2013, The number of people sickened by a bacterium found in some shellfish has more than doubled in the past week. A state Department of Agriculture official said 32 cases of the illness are either confirmed or under investigation. Of those, 14 were linked to clams and oysters harvested from beds off Westport and Norwalk, which were shut down earlier in August 2013 due to concerns about the bacterium. "It is an outbreak, at this point," said David Carey, director of the department's Bureau of Aquaculture. The state shut down the beds last week and issued a voluntary recall of shellfish harvested there over the last month [July to August 2013], due to high levels of the naturally occurring bacterium Vibrio parahaemolyticus. The bacterium, which rapidly multiplies in higher temperatures -- such as the heat waves that hit the region in July 2013 -- can cause acute gastrointestinal illness. There is a lag time between when the illness strikes and when it is confirmed, so more cases are expected to be identified in the coming weeks. Last week, just 5 cases in the state were linked to the bacterium. Of the 32 cases being looked into by the bureau -- which includes both Connecticut residents and reports from out of state -- 13 are still unconfirmed and 5 originated in harvest areas in other states. V. parahaemolyticus is generally found in uncooked fish, including crabs, shrimp and lobsters. It occurs in other kinds of fish as well, and some people have been known to become ill from it after eating sushi, said Dr. Rock Ferrigno, chairman of Bridgeport Hospital's emergency department. There have been no illnesses from this outbreak treated at Bridgeport Hospital, he said. Greenwich Hospital and Danbury Hospital also said they hadn't seen anyone with the infection. Stamford Hospital, on the other hand, has seen at least 4 cases, and at least one person was hospitalized, said Dr. Michael Parry, director of infectious diseases at the hospital. Typically, Parry said, vibrio-related illness causes diarrhea and other lower intestinal problems, but doesn't usually cause vomiting. "It's not usually life-threatening, but it can make you pretty sick," he said. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

E. COLI EHEC (ARIZONA): 16 August 2013, The number of people who became ill after eating at a Mexican food restaurant in Litchfield Park has climbed to 68. Maricopa County health officials are trying to determine what items were contaminated with Escherichia coli [O157] at Federico's Mexican Food restaurant at Camelback and Dysart roads. The sickened customers ate at the restaurant on or after 23 Jul 2013. Symptoms included severe abdominal cramps and bloody diarrhea. More than a dozen people were hospitalized. The restaurant closed on 2 Aug 2013 and threw away USD 10 000 worth of food. It reopened 3 days later after a county health inspector said it was in compliance. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

VIBRIO PARAHAEMOLYTICUS (CONNECTICUT): 15 August 2013, More than twice as many King County [Washington] residents have become ill after eating shellfish this summer [2013] as in past years. King County health officials report there were 13 suspected cases of the saltwater bacteria Vibrio parahaemolyticus in the county during July [2013], compared with an average of 4 reported in that month in recent years. Since the beginning of August [2013], an additional 8 cases have been confirmed, while King County would typically see only 6 in the entire month. Across Washington state, more than 40 residents have gotten sick with vibriosis. "This is probably the tip of the iceberg," said Dr. Jeff Duchin, chief of communicable disease for Seattle & King County Public Health. "For every case that is reported, an estimated 142 additional cases go unreported." People typically get vibriosis from eating raw or undercooked shellfish, particularly oysters. Residents who have pre-existing medical conditions or who take antacids regularly are at higher risk for illness from the vibrio infection. Symptoms of vibrio infection can include moderate to severe diarrhea, abdominal cramps, nausea, vomiting, fever, chills, and headache. Vibrio bacteria also can cause a skin infection if open wounds are exposed to warm seawater. To prevent vibrio infections, health officials recommend consumers thoroughly cook shellfish before eating them; never rinse cooked shellfish in seawater, which can re-contaminate them; keep raw or cooked shellfish well-refrigerated before serving; and avoid swimming in warm seawater if you have open wounds. Officials have recommended shellfish not be harvested from areas closed due to high vibrio levels, including Hammersley Inlet and several parts of Hood Canal. Oakland Bay and Totten Inlet growing areas are also closed due to recent illnesses. Health officials advised cooking shellfish until the shells just open is not enough to kill vibrio bacteria. Shellfish should be cooked to an internal temperature of 145 deg F [63 deg C] for at least 15 seconds. "We have warnings on menus about the risks of eating raw shellfish, but people might not always get the message or know that the risks are much higher this time of year," Duchin said. Kevin Davis, owner of Blueacre Seafood, knows that consuming raw oysters could lead to infection, but that doesn't stop him from eating one of his favorite foods. "While the risks involved with eating raw oysters are obviously greater during the warmer months, the temptation to enjoy a few freshly shucked, ice cold oysters on the half shell on a warm summer's afternoon far outweigh the risks for many people," Davis said. For consumers who aren't willing to assume that risk, Davis recommends broiling, grilling or frying oysters, which he said gets them even hotter than 145 deg F [63 deg C]. Davis also recommended buying oysters from a reputable source that keeps them in a cold environment and sells them fresh. "You want as clear a chain direct from the growers as possible," Davis said. The Washington State Department of Health has been sending notices to shellfish growers recommending extra precautions during periods of low midday tides and warm weather, and weekly lab test results showing the levels of vibrio bacteria in growing areas. Vibrio bacteria occur naturally in marine waters, and they grow more rapidly during the warm months. Health officials reported the early warm streak in July [2013] could have led to a longer period of vibrio presence in local waters. Once water temperatures begin to cool in October, the bacteria typically decline. Davis said that while oysters are most popular during the summer, they actually are most abundant and at their best quality during the winter and early spring, when they are safer to eat. "From September till May their whole existence is to feed, so all they're doing is getting better." The worst outbreak of vibriosis in recent years came in 2006, when Washington had 80 lab-confirmed vibrio cases and King County had 36 confirmed cases. In 2012, King County had 26 cases of vibriosis for the entire year; so far this year [2013], 22 confirmed or probable cases have already been reported. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CYCLOSPORIASIS (USA): 15 August 2013, As of 12 Aug 2013, the Centers for Disease Control and Prevention (CDC) has been notified of 539 cases of cyclospora infection from the following 19 states: Arkansas, California, Connecticut, Florida, Georgia, Illinois, Iowa, Kansas, Louisiana, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York (including New York City), Ohio, Texas, Virginia, and Wisconsin. Most of the illness onset dates have ranged from mid-June through mid-July 2013. At least 32 people are reported to have been hospitalized in 5 states. On 12 Aug 2013, FDA released information regarding the trace back investigation of Taylor Farms de Mexico salad mix and the company's decision to suspend "production and shipment of any salad mix, leafy green, or salad mix components from its operations in Mexico to the United States." It is not yet clear whether the cases from all of the states are part of the same outbreak. Additional cases are currently under investigation and will be included on this page as confirmed. Cases in this outbreak are defined as laboratory-confirmed cyclospora infection in a person with onset of illness since June 2013 and no history of travel outside of the United States or Canada during the 14 days prior to onset of illness. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

PLAGUE (NEW MEXICO): 13 August 2013, The New Mexico Department of Health confirmed today, 12 Aug 2013, a case of plague in a 15 year old boy from Torrance County who is currently hospitalized in stable condition. This is the 1st human case of plague in New Mexico and in the USA in 2013. An environmental investigation will take place at the boy's home to look for ongoing risk to others in the surrounding area. "The Department of Health conducts an investigation when a plague case occurs to ensure the safety of the immediate family, neighbors, and health care providers," said Department of Health secretary Retta Ward, MPH. "We inform neighbors door-to-door about plague found in the area and educate them on reducing their risk. Health care providers and others close to the patient may also have been exposed, and are assessed to determine if they need preventive treatment." Plague is a bacterial disease of rodents and is generally transmitted to humans through the bites of infected fleas, but can also be transmitted by direct contact with infected animals, including rodents, wildlife, and pets. "Plague activity in New Mexico is usually highest during the summer months, so it is especially important now to take precautions to avoid rodents and their fleas which can expose you to plague," said Dr Paul Ettestad, public health veterinarian for the Department of Health. "Pets that are allowed to roam and hunt can bring infected fleas from dead rodents back into the home, putting you and your children at risk." To prevent plague, the Department of Health recommends:
- avoid sick or dead rodents and rabbits, and their nests and burrows;
- keep your pets from roaming and hunting;
- talk to your veterinarian about using an appropriate flea control product on your pets as not all products are safe for cats, dogs, or your children;
- clean up areas near the house where rodents could live, such as woodpiles, brush piles, junk, and abandoned vehicles;
- sick pets should be examined promptly by a veterinarian;
- see your doctor about any unexplained illness involving a sudden and severe fever;
- put hay, wood, and compost piles as far as possible from your home;
- don't leave your pet's food and water where mice can get to it.

In New Mexico, there was 1 human plague case in 2012, 2 human cases of plague in 2011, no cases in 2010, and 6 human cases of plague in 2009, 1 of them fatal. (Plague is listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

INTERNATIONAL DISEASE REPORTS*

CRIMEAN-CONGO HEMORRHAGIC FEVER (INDIA): 17 August 2013, The dreaded Crimean-Congo hemorrhagic fever is suspected to have claimed lives of 3 men in Barvalataluka in Ahmedabad district [Gujarat state]. Following this, the health department has asked medical and veterinary teams to undertake fogging operations to contain the virus, which spreads through ticks found on the cattle. Regional deputy director of health at Civil Hospital Dr. Neelam Patel said that 3 men were reported dead in Kundal village in Barwala due to hemorrhagic fever suspected to be caused by Crimean-Congo hemorrhhagic fever virus. Moreover, 2 relatives of the victims, including a woman, have also been admitted to the Bhavnagar Government Hospital. The victims belong to Bharwad families staying in the same locality. District health officer Dr. Shilpa Jadhav said that the teams of health department and animal husbandry department have been sent to the village to carry out extensive antiviral operations and undertake cleanliness drives. The ticks, which are known to carry Crimean-Congo virus, are being plucked from the cattle. The officials said that the cleanliness drive has been undertaken in a 5 km [about 3 mile] radius of the village. Earlier, 4 people of Kariyana village in Babra taluka of Amreli district [Gujarat state] had died of confirmed Crimean-Congo hemorrhagic fever as their clinical samples had tested positive for Crimean-Congo hemorrhagic fever. In India, Crimean-Congo hemorrhagic fever virus 1st surfaced in Gujarat in January 2011 when a woman from Kolat village in Sanand died of the virus infection. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

CRIMEAN-CONGO HEMORRHAGIC FEVER (UGANDA): 16 August 2013, The Ugandan Health Ministry said on Friday [16 Aug 2013] that 3 people have died in northern Uganda from a suspected outbreak of a highly infectious hemorrhagic fever. A male farmer is still being treated as a confirmed case of Crimean-Congo hemorrhagic fever (CCHF), and the 3 other deaths are being investigated, junior health minister Elioda Tumwesigye told a news conference. Doctors at 1st suspected the farmer had Ebola [hemorrhagic fever], the highly contagious and lethal viral fever, after falling ill on 8 Aug [2013], with sudden headache, bleeding, high fever, joint muscle pain, vomiting, red eyes, back pain, and stomach pain. Subsequent tests showed it was CCHF. Caused by a tickborne virus, it is highly infectious and is endemic in livestock in Africa. It kills 40 per cent of all the people it infects, according to the Health Ministry. The ministry said it was tracking 6 other people who had come into contact with the sick farmer, being treated at Kalongo Hospital in Agago district, 450 km [280 miles] north of the capital Kampala, and that an isolation facility had been set up. Uganda has suffered several episodes of Ebola [hemorrhagic fever] and Marburg [hemorrhagic fever] since 2000. The most recent case was in October last year [2012] in Kabale, near the Democratic Republic of Congo, when Marburg virus killed 5 people. The largest outbreak of Ebola [hemorrhagic] fever in the country was in 2000 in the north of the country, which infected 425 people and killed more than half of them. Health services in Uganda are severely underfunded and understaffed with leading referral hospitals lacking basic medical supplies. The Ministry advised people to avoid close physical contact with animals and suspected infected people. (Viral Hemorrhagic Fevers are listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

E. COLI EHEC (ITALY): 15 August 2013, The Hemolytic Uremic Syndrome [HUS] Italian Registry System, in cooperation with the National Institute of Health (Istituto Superiore di Sanita [ISS], http://www.iss.it/seu) and the Italian Society for Pediatric Kidney Diseases (SINP), has been informed about several reported cases of HUS in patients resident in the region of Apulia [Puglia] or in people who traveled there before the onset of symptoms. Between 1 and 14 Aug 2013, 8 children and an adult patient were hospitalized after developing HUS. Most HUS cases are secondary to a Shiga toxin-producing Escherichia coli infection (also called an enterohemorrhagic E. coli or EHEC), with diarrhea, often with bloody stool, vomiting, and abdominal pain. Preliminary laboratory investigations performed by the National Reference Laboratory for E. coli at ISS on 2 patients revealed an infection with EHEC O26. Further investigation on the other cases is ongoing. The Apulia Region Health Authorities are conducting epidemiological investigations with Ministry of Health and the ISS. These activities have not been able so far to ascertain with certainty a common source of infection. Regional authorities are enhancing their epidemiological surveillance on local gastroenteritis activity, while the ISS sent an alert message to all Italian pediatric kidney diseases departments, through the SNIP, for early detection of other cases in the various regions, possibly linked to the Apulia outbreak. For the same reason, ISS sent an alert message to the European Center for Disease Prevention and Control (ECDC). (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

CHOLERA (AFGHANISTAN): 14 August 2013, A cholera outbreak at a village in north east Afghanistan has infected 1492 people, killed a young woman, and left another 100 in critical condition, a provincial official said on Tue 13 Aug 2013. Abdul Marouf Rasekh, a spokesman for the governor of Badakhshan province, said the outbreak began 3 days ago and was restricted to one town that has been quarantined. When it first appeared in the mountainous village of Chappa in the Darayen district, Rasekh said it infected 850 people but quickly spread until the quarantine was put in place. Rasekh said the source of the infection had been traced to a single spring of water that supplies the entire town's drinking water. Health authorities were bringing in water from nearby towns until the problem was solved. He said that 36 of the most serious cases have been taken to a hospital in the provincial capital of Faizabad and that the sole death so far was an 18 year old woman. Afghanistan has had cholera outbreaks in the past but they are not common. Typhoid and other intestinal diseases and parasites are far more common but not as deadly if left untreated. Access to clean drinking water is a problem in rural Afghanistan and health care is rudimentary in large parts of the country, which has one of the world's lowest life expectancies at 50. Only 12 per cent of Afghans living in rural areas have access to clean drinking water, according to the US Agency for International Development. (Water Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *Non-suspect case

ANTHRAX (BANGLADESH): 14 August 2013, According to the latest update of the Institute of Epidemiology, Disease Control and Research (IEDCR), Bangladesh, 5 new cases of [human] cutaneous anthrax have been reported in the 1st week of August 2013 from Gangni upazila of Meherpur district, bringing the total number of reported cases in that upazila this year [2013] to 87. To date in this year [2013], 175 cutaneous anthrax cases have been reported in 4 districts in Bangladesh: Shirajganj 12, Tangail 76, and Meherpur 87. (Anthrax is listed in Category A on the CDC List of Critical Biological Agents) *Non-suspect case

*National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

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Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable